Champlain Diabetes Chiropody Program- **Referral Form**

Please Fax *Completed* Referral to **613-774-7241**

Tel: 613-783-7760 Toll free: 1-888-220-8010

Please note: Admission to services is not guaranteed and client could be put on a wait list

All incomplete forms will be returned to the referring provider. All fields are mandatory.

Referring Provider: _____ Phone Number: (_____)_____

Fax Number :(_____)_____ Request communication back? ☐ Yes ☐ No

Client Information:

Last Name: _____ First Name: _____

DOB: (YYYY)/(MM)/(DD) _____/___/____ Gender: ☐ M ☐ F ☐Other:_____

Phone: (_____)_____ Alternate Phone: (_____)_____

Address: _____

OHIP#_____ V.C._____ Primary Care Provider: _____

Language: ☐ English ☐ French ☐ Other: _____ Client HbA1C:_____

Client has: ☐ Type 1 Diabetes ☐ Type 2 Diabetes (Insulin, Oral and/or Diet) ☐Pre Diabetes

Current Medications:_____

Medical History:_____

Referral for:

☐ Open wound/foot ulcer (Please also refer to CCAC for nursing care.) If you are a physician/NP:

☐ Check box to allow Chiropodist to request Vascular and/or Infectious disease consult as needed

Physician/N.P Signature:_____ OHIP Billing# _____

Both Signature and OHIP Billing Number is required for the consult above

☐ Ingrown toenail with bacterial infection (Please start antibiotics if infection present)

Additional Comments (Summary/Medical History/Medications/Allergies may be attached):

Our clinics provide services for diabetic foot ulcers
and ingrown toenails with bacterial (not fungal) infections
We do not provide routine foot care.

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